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The 'British Policy Style' and Mental Health: Beyond the Headlines

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Abstract

Recent Mental Health Acts provide evidence of diverging UK¹ and Scottish government policy styles. The UK legislative process lasted almost ten years following attempts by ministers to impose decisions and an unprecedented level of sustained opposition from interest groups. In contrast, the consultation process in Scotland was consensual, producing high levels of stakeholder 'ownership'. This article considers two narratives on the generalisability of this experience. The first suggests that it confirms a 'majoritarian' British policy style, based on the centralisation of power afforded by a first-past-the-post electoral system (Lijphart, 1999). Diverging styles are likely because widespread hopes for consensus politics in the devolved territories have been underpinned by proportional representation. The second suggests that most policy-making is consensual, based on the diffusion of power across policy sectors and the 'logic of consultation' between governments and interest groups (Jordan and Richardson, 1982). The legislative process deviated temporarily from the 'normal' British policy style which is more apparent when we consider mental health policy as a whole. Overall, the evidence points to more than one picture of British styles; it suggests that broad conclusions on 'majoritarian' systems must be qualified by detailed empirical investigation.

Introduction

The term 'policy style' refers to the way that governments make and implement policy (Richardson, 1982: 2). The key concern of this article is how best to characterise the British policy style: with reference to a 'majoritarian' government that exploits the centralisation of power to impose policy decisions without consultation, or to the diffusion of power across policy sectors and consensual relationships between groups and government? Lijphart (1999) sets up a simple distinction between policy styles in countries which use plurality and proportional electoral systems: the former exaggerates governing majorities, produces a concentration of power at the centre and encourages majoritarian, top-down government; the latter diffuses power and encourages the formation of coalitions and pursuit of consensus. In this light, devolution raises the prospect of differing policy styles *within* Britain, since the proportional electoral system in Scotland encourages consensus, and devolution produced hopes for

a new style of politics, 'radically different from the rituals of Westminster: more participative, more creative, less needlessly confrontational' (Scottish Constitutional Convention, 1995).

In contrast, Richardson *et al.* (1982) argue that different political systems produce similar policy styles. Most (Western European) countries share a common 'standard operating procedure' based on consultation and the need to seek consensus. Political systems are broken down into policy sectors, with power spread across government and shared with interest groups. This suggests that descriptions of a Scottish departure from 'old Westminster' politics may be based on a caricature of UK government behaviour which is not confirmed empirically. Indeed, recent evidence (Cairney, 2008) suggests that a similar 'logic of consultation' (Jordan and Maloney, 1997) with the most interested, active and knowledgeable interest groups exists across Britain.

The first aim of this article is to situate recent Mental Health Acts pursued by the UK and Scottish governments within the policy styles debate (since the UK Acts cover England and Wales and there is no equivalent legislation for Northern Ireland, this precludes a discussion of their government's policy styles).² It argues that this experience supports the majoritarian narrative and highlights the most significant divergence in Scottish and UK government consultation styles since devolution. The *Mental Health Act 2007* followed a ten-year stand-off between UK ministers and the vast majority of interest groups which united under the Mental Health Alliance (MHA) to oppose government legislation. In contrast, the process in Scotland was consensual. The Scottish Parliament passed the relatively comprehensive *Mental Health (Care and Treatment) (Scotland) Act 2003* in less than four years.

The second aim is to extend the analysis to wider UK government mental health policy. It highlights not only a consensual legislative process in the past, but also the promotion of consensus on other issues. The result was smoother group/government relationships during the reform of mental health services and in the lead up to the *Mental Capacity Act 2005*. This supports the consensus narrative and prompts us to explain why particular examples of top-down policy-making depart from the 'normal' policy style (Jordan and Richardson, 1982: 81).

Comparing narratives of policy styles

The majoritarian narrative suggests that policy styles flow from electoral systems and the distribution of power. Under proportional systems, power is dispersed across parties, encouraging the formation of coalitions based on common aims. This spirit of 'inclusiveness, bargaining and compromise' extends to the relationships between group and government, with groups more likely to cooperate with each other and governments more willing to form corporatist alliances (Lijphart, 1999: 2-3). In contrast, the plurality system exaggerates

governing majorities; control of the legislature is held by a single party and power is concentrated within government. This asymmetry of power extends to the group—government arena, with groups more likely to compete with each other and governments more likely to impose policy from the top-down.

The majoritarian narrative was reinforced during the Thatcher era of government. Marsh and Rhodes (1992: 8) describe a period in which government made policy choices, 'unencumbered by the constraints provided by interest groups'. It reduced consultation, challenged past relationships and set a stronger top-down agenda (Richardson, 2000: 1010). This image of the UK government style influenced narratives of 'new politics' in Scotland, with hope that the new Scottish Parliament would depart from the politics of 'old Westminster' (Scottish Constitutional Convention, 1995). This included plans for a proportional electoral system, to share power between parties and encourage coalition-building, and the widening of participation with groups to resist the temptation to internalise policy formulation (McGarvey and Cairney, 2008: 13).

New interview data suggest that the aim of widened group participation was realised. The larger project on comparative public policy draws on over 300 interviews conducted in Scotland, England, Wales and Northern Ireland from 1999 to 2007.³ An extensive series of interviews (over 100) with interest groups (professional, voluntary, business, trade union, religious) and civil servants in Scotland from 1999 to 2007 suggests that close partnerships have developed, with groups reporting high levels of satisfaction when engaging with government (Keating *et al.*, 2009; Keating and Stevenson, 2001; Keating, 2005). The process is more 'open and consultative' and groups point to the ease of access, with civil servants (and often ministers) a 'phone call away' (see McGarvey and Cairney, 2008: 236). Many also signal a desire within government to foster collaborations between groups. The assumption from most interviewees is that this contrasts with a top-down UK government style in which the process is more formal, ministers and senior civil servants are more aloof, and more policy is pushed through in the face of opposition. In other words, Thatcherite top-down policy-making was succeeded by Blair's 'Presidentialism' (Bevir and Rhodes, 2006). This image is reinforced by Greer and Jarman (2008), who link the imposition of market mechanisms, competition and diversity in the delivery of public services to a mistrust of public sector professionals. Overall, this narrative suggests that the UK government style has become top-down, with consultation and negotiation replaced by conviction politics and persuasion which appeals to ideology or the public interest.

In contrast, the consensus narrative suggests that the 'logic of consultation' often produces stable arrangements within policy communities or close-knit policy networks (Jordan and Maloney, 1997). Richardson (1982) highlights a strong tendency for the emergence of a common, 'European policy style'. Although the political structures and electoral systems of each country vary,

they share a 'standard operating procedure' based on two factors: an incremental approach to policy (which suggests that radical departures from policy decisions negotiated in the past are rare) and an attempt to reach consensus with interest groups rather than impose decisions. The logic underpinning 'bureaucratic accommodation' of the most affected interests is strong since it encourages group ownership of policy and maximises governmental knowledge of possible problems. Further, the size of the state and scope for 'overload' necessitates breaking policy down into more manageable sectors and sub-sectors which are less subject to top-down control. Ministers and senior civil servants devolve the bulk of decision-making to less senior officials who consult with groups and exchange access for resources such as expertise.

The consensus narrative is also supported by new interview data. Approximately 70 interviews were conducted from 2006–7 with equivalent UK interest groups and civil servants in the 'most devolved' policy areas (health, education, local government). Similar questions – on the nature and frequency of contact with ministers and civil servants – were asked (see Cairney, 2008). The evidence suggests that a similar logic of consultation exists across the UK. This relates to the remarkable ability of UK government departments to compartmentalise and treat issues differently even when they involve the same participants at the same time. For example, although the British Medical Association and Royal College of Nursing have had very public disagreements with the government on key issues, beyond the headlines they maintain a day-to-day relationship on a wide range of others (interviews, 2006). Similarly, although the issue of key-stage testing for school pupils was, for a long time, 'non-negotiable', most teaching unions still enjoyed a close relationship with the Department for Children, Schools and Families through its 'social partnership' (interviews, Association of Teachers and Lecturers; Professional Association of Teachers; Association of School and College Leaders, 2006). Further, the Local Government Association has a good working relationship with the Department of Communities and Local Government, despite its vocal concerns over central government interference (interview, LGA, 2006), while voluntary groups report valuable contacts with a range of government departments even if they disagree with the policies of some (interviews, National Council for Voluntary Organisations; Help the Aged; NCH, 2006).

This evidence suggests that, while we may witness the periodic rejection of consultation by ministers pursuing a small number of high-profile issues, the picture changes if we examine lower-profile issues and lower levels of government in which most policy development takes place (Cairney, 2002; Page, 2006). On this basis, levels of consultation remained consistently high under Thatcher (Jordan and Richardson, 1987: 30; Maloney *et al.*, 1994: 23), while Labour's election met with a 'major increase in consultation', particularly with voluntary sector groups (Marsh *et al.*, 2001: 194). Indeed, Kriesi *et al.*'s (2006) study of

seven Western European countries confirms the findings of Richardson (1982): the British style resembles 'more closely those expected for consensus than for majoritarian democracies' (Kriesi *et al.*, 2006: 357; Adam and Kriesi, 2007). This image of the UK government suggests that the majoritarian narrative exaggerates differences in policy styles between the UK and devolved governments. This article extends these issues – and the same methodological approach – to mental health. Semi-structured interviews were conducted from 2006–7 with key civil servants (including members of the UK and Scottish mental health bill teams), members of the UK and Scottish mental health review teams, representatives from the Scottish voluntary, social work and psychiatric sectors, a range of groups within the Mental Health Alliance (at chief executive and/or policy manager levels) and the Zito Trust.

Policy styles and mental health

Different aspects of mental health policy provide evidence for different narratives. Recent Mental Health Acts provide strong evidence to support the majoritarian narrative. They demonstrate, and show the value of, Scotland's alternative policy style. However, a wider discussion over time and across policy issues suggests that the UK government style rarely produces such adverse consequences for policy development. The consensus narrative suggests that Mental Health Acts are unrepresentative in two main ways. First, they apply to a small proportion of the mental health population. Second, the UK government has a long history of consensus in mental health legislation; this continued when the government was consulted on mental health services and mental capacity. Therefore, the *Mental Health Act 2007* may represent an atypical case which reveals the costs of imposition that cannot be sustained across the board. In this light, the consensus narrative prompts us to explain why the UK government departed from the 'normal' style. To demonstrate these issues, this article:

- compares the post-war history of mental health legislation with the present day, to explain the shift in government attention from the consensual patients' rights agenda to the imposition of measures linked to public safety;
- compares the UK and Scottish legislative processes, to explain why Scotland did not follow the UK government's public safety agenda; and
- compares the Mental Health Act with the UK government's policies on mental health services and mental capacity, to highlight the factors which influenced the change in style.

Comparing 1983 and 2007

The constant factor in mental health is that, compared to physical health, there is a much wider spectrum of beliefs among pressure participants. This ranges from the 'medical model' at one end to the belief that mental illness is a social

construct at the other. There are also significant divisions *within* the psychiatric profession, user groups and mental health charities (Pilgrim, 2007: 90). The main disagreement on legislation refers to the balance between patients' rights and coercion for the broader social good. This debate has traditionally been played out by human rights advocates and psychiatrists, reflecting 'the tension between the patient's right to liberty and the psychiatrist's "right to treat"' (Pilgrim, 2005: 440). What has changed is the way the government managed these competing demands:

I was on the bill team for the 1983 Act. That was a piece of consensus legislation, as was the 1959 Act. So the tradition is consensus. The new Act is the first departure from that. The UK has had a proud history and place in the world in mental health and is currently throwing that out. So this Act represents a blip in political history (interview, former Department of Health official, 2006).

In the post-war period, the government acted mainly as a referee, consulting with groups and seeking resolution to opposing views. Relations between groups and government were consensual, based on a broad commitment to service modernisation and patients' rights (interview, British Association of Social Workers, BASW, 2006). The *Mental Health Act 1959* reversed the emphasis of pre-war Acts (on the power to detain) by establishing voluntary psychiatric admissions (although see Pilgrim, 2007). However, it was unclear on the discretion of the medical profession to impose treatments on patients subject to compulsory detention. The 1983 Act was necessary to provide clarity and it was pursued by mental health organisations as an opportunity to reduce medical discretion, introduce safeguards and further patients' rights. The main aspects of the 1983 Act flowed from this premise: legal controls on the imposition of medical procedures when a patient was subject to the Act, a tribunal to review the cases of people detained, the introduction of a Mental Health Act Commission to evaluate the treatment of patients, and Approved Social Workers to develop mental health expertise outside the psychiatric profession.

The long gap between Mental Health Acts meant that for most groups the prospect of new legislation in the late 1990s represented a 'once in a generation' chance to further patients' rights. However, when it became clear that the government was pursuing a 'punitive' agenda, the historical tension between groups was replaced by almost uniform opposition to the government:

The debate shouldn't be dominated by the dangerousness agenda. Most experiences with mental health suggest that the problem is not violence but mostly about getting help when needed; access to services. So the Mental Health Alliance's agenda was to say: here is an opportunity to change mental health legislation and create a legislative framework for rights to access, not reasons for compulsion (interview, Mind, 2006).

Therefore, the problem to be explained is the shift from a consensus model based on advancing patients' rights to a top-down approach based on

public safety. The decision-making context differed in four main ways. First, by 1997 the policy conditions in England had changed because of the unintended consequences of previous policies. The main development was a rapid shift from hospital to community-based treatments which caused a rise in media and public concern about the dangers of mentally ill people living in the community (Gostin, 2000: 139). This was compounded by the introduction in 1996 of independent inquiries for homicides committed by a person who had contact with specialist mental health services in the preceding six months. Although inquiries were supposed to reassure the public by establishing the facts, identifying lessons to be learned and giving an explanation to the relatives of the victim, they provided further focus for media interest in individual cases, such as the murder of Jonathan Zito by Christopher Clunis (Paterson and Stark, 2001: 261). Homicides were often reported three times: after the attack, during criminal proceedings and during the inquiry. In turn, the new climate of fear and 'changing societal pressures on psychiatrists away from libertarianism and towards coercion' affected psychiatric practices, with the use of the 1983 Act to 'section' patients doubling from 1984 to 1996 (Hotoph *et al.*, 2000: 479; see also Szmukler and Holloway, 2000: 196).

Second, the perceived pressure to respond to the European Convention on Human Rights (ECHR) changed. Previous European Court of Human Rights rulings related to the rights of the individual when detained (Gostin, 2000). However, in 1998 the Court ruled in the case of *Osman versus the United Kingdom* (Gavaghan, 2007). This involved a teacher who became so obsessed with one of his pupils that his actions escalated to shooting Osman and his father. The Court probed the likelihood of the police being able to prevent the attack based on previous behaviour. It took seriously: (a) the extension of Article 2's focus on the right to life, from states *not killing their citizens* to *protecting citizens* from threats from third parties, and (b) the suggestion that police authorities were not immune from legal redress if they did not protect the public. The government reacted to the possibility of being held responsible for a homicide committed by a person whose behaviour was previously reported to the authorities. Further, since the ruling related to the police, the Home Office became the lead department, creating the term DSPD (Dangerous People with Severe Personality Disorder) as a means to: (a) identify those people who were mentally ill but largely untreatable under the old Act, and (b) subject them to preventative detention within the mental health system (since preventative detention is only ECHR compatible if the person is of 'unsound mind' (Eastman, 1999) and other conditions have been met (Prior, 2007)).

Third, in 1983, there was either no equivalent governmental interest in the issue, or mental health tied in with different 'big issues' of the day. Ministerial interest in legislation peaked when David Ennals was appointed as Labour's Secretary of State in the Department of Health and Social Security from 1976–9

(Ennals was previously the campaign director of Mind). Yet mental health was not a priority, with Ennals' time taken up by public sector pay and the new child benefits system (Roberts, 2003; Glennerster, 2004). The legislation drifted under Labour, then took four years to pass under a Conservative Government. Most Conservative interest focused on mental health service *delivery*, using the agenda on care in the community to accelerate the move from old hospital-based to new community-based settings for mental health care (Rogers and Pilgrim, 2001). The issue of mental health was therefore 'framed' differently. In the lead up to 1983, Mind had conducted a five-year campaign to highlight patients' rights, and when mental health hit the headlines, it tied in with the inadequacies of psychiatric hospitals (interview, Larry Gostin, former Mind legal officer, 2006).

In contrast, by 1997 mental health had become associated with public safety, with a rise in the number of media stories on dangerous people roaming the streets, committing homicides, and/or deemed untreatable and not subject to compulsion (Cutcliffe and Hannigan, 2001; Paterson and Stark, 2001). The New Labour government therefore took a more direct interest in mental health as part of its commitment on crime, order and public safety (with compulsion in the community periodically referred to as 'mental health ASBOs'; interview, Rethink, 2006). Since mental health became framed as an issue of safety, the Home Office became a major player in legislative development, with Jack Straw crediting himself with identifying the need for a new Act when Home Secretary (Hansard 11.5.06 Col. 516).

Fourth, the biggest conflicts in 1983 were between groups. Mind was the most prominent group pursuing patients' rights, while the Royal College of Psychiatrists and SANE were *at the time* more likely to defend professional discretion (interview, MHA, 2006). Debates were refereed by government, and low ministerial interest resulted in policy development at a low civil service level. Civil servants accommodated groups in two notable ways: by drawing heavily on work published by Mind on patients' rights (Larry Gostin of Mind is often credited with writing two-thirds of the Act) and by supporting group pressure in Parliament, with many addressing the standing committee directly and much 'horse-trading in the corridors' producing a series of late amendments (interview, BASW, 2006; interview Gostin, 2006). In contrast, from 1998 to 2007 the biggest conflicts were between groups and ministers who made pronouncements on the nature of the bill before consultation (interview, MHA, 2006). The consultation process changed, with: (a) meetings between mental health groups and the Department of Health running parallel with a Home Office review of detaining people with untreatable personality disorders; and (b) a period of reinvention within key groups, such as the RCP (now more likely to question the role of the psychiatrist in detention; interview, RCP, 2006) combined with a rise in service user groups focused on patients' rights (Rogers and Pilgrim, 2001).

The Mental Health Act 2007

The combination of unusual government interest, public safety, a top-down consultation style and a convergence in group attitudes against the legislation produced an unprecedented level of conflict between groups and government. Yet initial policy developments suggest that the shift to a public safety agenda was by no means inevitable and that groups can be persuaded to support controversial legislation. The process began as it had done in the past, with a broad compromise achieved by the Richardson Committee in 1998 (Department of Health, 1999b). Key to this process was a way to satisfy the Royal College of Psychiatrists, who were opposed to becoming 'jailers', about their obligation to impose compulsory treatment against a patient's competent refusal, and to placate mental health charities and user groups about the shift of attention from patients' rights towards compulsion and safety. This was achieved with the idea of entitlement: that if you enforce compulsory powers over an individual, then they are entitled to a minimum quality of care (interview, Richardson Committee member, 2006). The committee argued that if the state used its powers, then rights and services should follow. This was an effective argument for those with experience of the 1983 Act, since its use was often to secure a patient's admission without necessarily providing adequate treatment (interview, Turning Point Scotland, 2006).

If the report's conclusions had been accepted, then the UK government would have beaten Scotland to the punch and maintained a consensual style. However, three factors help explain a departure from this route. First, the status of the Richardson Committee was limited. The government did not want to set up a Royal Commission since this would have the scope to consider policy, while an interdepartmental working group would not provide sufficient legitimacy for the community treatment proposals. The middle way was an external advisory committee with limited terms of reference. The appointment of Richardson, a legal academic (rather than the heavyweight former Secretary of State in Scotland), was also significant. Initially the committee was given an impractical timetable, and when a three-month extension was granted, there was still concern about how much consultation it could 'indulge' in. Successive ministers then criticised the committee's conclusions and the report was delayed until the publication of the Green Paper, to limit debate before the government's intentions were made public (interview, Richardson Committee member, 2006). Second, Home Office influence was considerable. A separate parallel interdepartmental group to consider DSPD was set up, while Home Office civil servants also attended the Richardson meetings. This raised suspicions among the MHA that the agenda was set by the more powerful Home Office, with public safety taking precedence over patients' rights. It also shifted consultations on DSPD to the main clients of the Home Office dealing with more 'grave offences' and secure units, reducing consultation with social workers who had more experience of magistrate courts (interview, BASW, 2006). Third, the government rejected many aspects

of Richardson's report, including the recommendation on entitlement, because it believed the legislation should relate only to legal aspects of compulsion and rights. This symbolised a philosophical difference between a government keen to solve the problem of preventative detention and a mental health policy network expecting (like 1983) to extend the agenda on patients' rights (interview, MHA, 2006).

The Green Paper departed from Richardson's recommendations in three main ways:

- The driver was public safety rather than the principle of non-discrimination and autonomy.
- The concept of 'capacity' was deemed irrelevant to safety, while the need to demonstrate that a patient's condition was 'treatable' was rejected. Richardson had introduced compulsion either in the absence of capacity to consent, or to override informed refusal when a serious risk of harm (to the patient or public) was apparent and clinical measures were available to improve, or stop the deterioration of, the patient's mental health.
- There was no trade of entitlement for compulsion.

In subsequent consultations, the issue of 'treatability' polarised the opinions of groups and government (interview, King's Fund, 2006). Many groups suspected that the Home Office was using the case of Michael Stone as a test of the legislation's effectiveness. Stone suffered from a form of personality disorder generally deemed untreatable by the psychiatric profession. Therefore, under the 1983 Act it would not have been possible to detain Stone before he became dangerous; the test applied to legislation was whether or not it could have identified and detained Stone (using the new term DSPD) before he attacked Lin and Megan Russell (interviews, Mental Health Foundation, MHF; MHA; BASW, 2006). The White Paper in 2000 produced further criticism that it did not respond to concerns about compulsory community treatment and that the 'net' of detention would be too wide (since compulsion would not have regard to capacity or therapeutic results). This stance alienated most groups and united them in opposition to government. The Mental Health Alliance was formed by the major mental health charities (Rethink, Mind, Mental Health Foundation, Sainsbury Centre for Mental Health) and joined by user groups such as National Voices Forum, as well as the Royal College of Psychiatrists and SANE.

Such was the level of opposition that: (a) only one group – the Zito Trust set up to advance the rights of victims – declined the invitation to join; and (b) there began a long drawn out period of conflict. The Draft Bills in 2002 and 2004 were opposed by the MHA which argued that the government had failed to respond to criticisms of the Green and White Papers. In 2005, the bill was recommended for parliamentary pre-legislative scrutiny. Although this was described by the government as a way to seek consensus, the MHA saw it as a

way for the government to legitimise controversial policies. The result was the production of over 100 recommendations for change, many of which came from the MHA. By 2006, the government decided to introduce a much shorter bill which merely amended the 1983 Act.

The basis for MHA opposition was a reaction to ministerial pronouncements and a belief that there was no hope for negotiation (interview, MHA, 2006). In turn, their criticisms strengthened the resolve of successive ministers in the Home Office and Department of Health who passed on their non-negotiable positions through the generations (interview, Department of Health, 2006). Mental health therefore represents an unusual case in the literature – *one of often low ministerial interest but consistently high commitment*:

Were there peaks and troughs in ministerial interest? In interest yes, but in commitment no. If it didn't need to be on their desks then it wasn't, but if it was then there was still staunch support. There was never any wavering in the variety of ministers across two departments . . . [against] the stakeholders' position. It was trench warfare, about people retreating and hurling stones from both sides. When they behave that way it reinforces itself. The position is passed down the ministerial generations and the Mental Health Alliance and the entrenched positions were over-amplified (interview, Department of Health, 2006).

Both sides became guilty of exaggerating the effects of the legislation on civil liberties or public safety and their positions became further entrenched over time. Jordan and Richardson's (1982) analysis suggests that this stand-off is temporary; the civil service becomes the conduit for both sides and leads negotiations outwith the glare of publicity. Yet in this case, the usual channels were blocked. First, civil servants saw their role as defending the government's agenda rather than encouraging the exchange of information and advice (interview, Law Society, 2006). Second, the links between members of the MHA and the Home Office were not well established. Third, the process went on for so long that it was affected by civil service (and interest group) turnover, as well as a major reorganisation within the Department of Health, which saw a reduction in the number of professional appointments (which were a useful way-in for group members with shared backgrounds). Both sides were poles apart and ministers knew that if they asked groups how to legislate on DSPD, pressure participants (including the government's own bodies such as the Mental Health Act Commission and the Mental Health Review Tribunal) would say 'don't do it' (interview, BASW, 2006). Therefore, the process of bureaucratic accommodation broke down and the issues were played out in public and parliamentary arenas.

The Mental Health (Care and Treatment) (Scotland) Act 2003

Early indicators suggested that the Scottish Executive (now Scottish Government) would follow a similar path towards public safety. First, the earliest piece of

legislation passed by the Scottish Parliament was an Emergency Act to close a 'loophole' raised by the case of Noel Ruddle (SPICE, 1999a, 1999b). Ruddle was convicted of culpable homicide in 1992 but ordered to be detained indefinitely at the Carstairs State Hospital after a diagnosis of paranoid schizophrenia. By 1994, his diagnosis had changed to personality disorder and, by 1998, the hospital concluded that no effective treatment was available. This allowed Ruddle to apply successfully for his own release. The new legislation required that the courts and Scottish ministers take public safety into account as a criterion for continued detention, even if the level of treatability for personality disorder is uncertain. This remained in the 2003 Act despite objections from the Millan committee (interview, Bruce Millan, 2006). As a result, there were similar feelings among groups that a mental health act would send the wrong message and reinforce stigma, with the agenda on compulsion associating mental health with a small number of detained people, and the expense of the new legislation diverting funds from more positive representations of mental health (interviews, Scottish Association for Mental Health, SAMH; Penumbra, 2006).

Second, the Scottish legislation contains many proposals which were opposed in the UK. This includes compulsory treatment orders for patients in the community and measures relating to invasive procedures against a patient's will (if they have impaired decision-making). Indeed, the concerns of SAMH towards community-based compulsion were similar to Mind's. Both suggested that the use of compulsion was previously curtailed by the lack of hospital beds. Therefore, the new Act would increase compulsion since it was not linked to the availability of beds. Both suggested that psychiatrists saw the orders as useful for patients not already subject to compulsion but not taking their medication, while the reduced need for beds may allow long-term compulsion orders (interviews, SAMH; Mind, 2006). Third, the link between issues of crime and personality disorder was also dealt with separately, by the MacLean Committee set up by the UK Government before devolution.

The difference was a relatively consensual and straightforward consultation process. This began in 1999 with the appointment of Bruce Millan who, as a former Secretary of State for Scotland, was highly regarded politically. Millan had a say in the membership of the review team (Richardson did not) and stated that he would not accept a tightly prescribed agenda and timetable (interview, Bruce Millan, 2006). The review took two years to conduct, with two major consultation exercises: the first early on to gather broad views and the second towards the publication of Millan's recommendations, to give people the chance to respond to the final report (Scottish Executive, 2001). This created a feeling among groups that they had a genuine opportunity to influence policy (interviews, BASW Scotland; National Schizophrenia Fellowship Scotland; Penumbra; MHF Scotland, 2006):

Consultation in Scotland is a big thing and the process was lengthy, seeking to engage with stakeholders in a way not seen in England . . . So it was quite difficult to oppose the legislation when it was introduced, because it was seen to be so thorough and engaging and so difficult to argue against. On community-based orders, their opinion was at odds with ours but they seemed to take on board our concerns, which is evident in the report (interview, SAMH, 2006).

The widespread sense of 'ownership' extended to the legislative process, when groups were called on by the Scottish Executive to support their case (interview, Health Committee adviser, 2006). The result was a number of distinctive strands to the Scottish Act:

- A justification for legislation couched in terms of the benefits, rights, care and treatment for the individual.
- A higher threshold of risk before a person is detained.
- An automatic right to be heard by a mental health tribunal within 28 days.

Yet the experience demonstrates that the style of policy-making was as important as the substance of policy. This is the view of civil servants in the Department of Health (interviews, 2006) who argue that the differences between the Acts do not justify the differences in reaction: both bills contain elements that groups are not happy with; the reference to principles will not make a practical difference; the use of impaired decision-making in Scotland will not make a difference in practice, since clinical discretion will be similar in both territories; and both bills continue the principle of last-resort compulsion for a very small number of patients. It is also a view presented by interviewees in England, suggesting that the initial bill was 'not all bad', that few could provide a workable alternative to the provisions, and that the Scottish Act was flawed (interview, King's Fund; Mind, 2006). Indeed, most participants in England were happy with the prospect of statutory advocacy, the extension of mental health tribunals and changes to the rules on naming a nearest relative. Yet the stand-off between groups and government affected the substance of policy since many of the original bill's proposals (which both groups and government agreed on) were lost when the government withdrew it in favour of a much smaller bill less likely to be opposed in Parliament.

Policy conditions in Scotland and England

Although policy styles do matter, they are not always different in Scotland and England. Rather, they are influenced by conditions specific to decision-making environments. Some policy conditions in Scotland produce *systematic* differences. For example, the size of Scotland makes it easier to consult, manage relationships personally and minimise conflict over access to decision-makers (McGarvey and Cairney, 2008: 236). The smaller size of government also reduces policy 'silos' and the lack of communication between separate departments dealing with crime, mental health and mental capacity (in this case, civil servant

Colin McKay was secretary to both the Millan and MacLean committees and then the head of the mental health bill team). Some conditions produce *systematic but temporary* differences. For example, the Millan review in Scotland coincided with the advent of devolution and the widespread desire to make devolution work. This suggests a honeymoon period between groups and government, with a greater likelihood of negotiation and exchange (McGarvey and Cairney, 2008: 217). It also suggests that the primary motivation for the Scottish Executive was consensus, in contrast to New Labour in England, which was driven by the need to appear tough on crime and public safety.

Some policy conditions only affected the development of mental health acts. First, slower rates of hospital closures in Scotland from the 1960s produced fewer high-profile cases of homicides, associated with mental illness and a lack of hospital beds, by the 1990s. Second, the treatment of personality disorder in high-security hospitals has differed in Scotland since the 1970s. This followed a breakout attempt from Carstairs by two patients who killed a fellow patient, a nurse and a police officer in the process. The consequence was psychiatric resistance to the hospitalisation of people with untreatable personality disorders. This meant that a policy of preventative detention following the diagnosis of DSPD was less realistic because the hospital and professional capacity did not exist (interview, Colin McKay, 2006). Third, there is less justice department influence. The clearer separation between crime and health means there is no Scottish equivalent to the Home Office's role with offenders in secure psychiatric units (interview, Colin McKay, 2006). Fourth, in England, the issue of DSPD was considered by a Home Office-sponsored committee and then shoehorned into the Mental Health Act. In Scotland the reviews produced separate legislation. The MacLean recommendations were also sympathetic to Millan's, with a recommendation against following England's approach to DSPD and in favour of a focus on risk (Scottish Executive, 2000). Finally, Scotland did not introduce an inquiry process to examine individual homicides. Rather, these were investigated by the Mental Welfare Commission for Scotland which produced an annual report with a consistent message: good quality care and treatment is the key to minimising these cases (interview, MWCS, 2006).

These policy conditions, which are restricted to issues of compulsion in mental health, help explain why the UK, but not Scottish, government diverted from the 'normal' policy style. The rate of hospital closures, media attention to inquiries and level of Home Office influence was not as apparent in Scotland. Scotland had a weaker public safety agenda and its government was less likely to challenge strong opposition from practitioners (McGarvey and Cairney, 2008: 203; Keating, 2005). Therefore, crucial differences in the decision-making environment shaped the policy style in each country. By extension, if these policy conditions are absent across English mental health policy as a whole, then the 'British policy style' may be more apparent in other areas.

The National Service Framework and the Mental Capacity Act 2005

Most groups contrast their Mental Health Act experiences with consultation to develop the National Service Framework for mental health. This involved a huge range of stakeholders led by the Institute of Psychiatry; the momentum for collaboration was positive, with a general feeling that the government was willing to engage and develop policies that most groups would support (interviews, MHF; Together, MHA; Mind; Rethink; King's Fund, 2006). This was influenced by the tone of the framework which points out that: mental illness is common but carries too much stigma, most patients are vulnerable rather than dangerous and mental health needs to be given as high a priority as coronary heart disease (Department of Health, 1999a). The difference in style is not surprising given the agenda of expansion and improvement, the absence of controversial issues such as compulsory detention, and the lack of ministerial and media interest. Therefore, groups and civil servants could engage on the details with minimal external attention.

Perhaps more impressive is the wide consensus generated around the Mental Capacity Act, since the government faced similar media pressures. In this case, there were key differences with the Mental Health Bill. First, there was more consensus around the need for new legislation (which was promoted by the Department for Constitutional Affairs). There was no public safety driver or link to the Home Office and no sense of stigma in the policy tone. The Making Decisions Alliance (which had a membership very similar to the MHA) was supportive of government legislation and credits itself as a crucial factor in its introduction (see <http://www.makingdecisions.org.uk/>). Second, the 'common enemy' was not the government but an alliance of groups opposed to assisted dying (see www.carenotkilling.org.uk). Consultation between the government and the MDA was therefore more productive and revolved around key principles similar to those adopted by Richardson: the assumption of a person's capacity, the pursuit of means to help that person make decisions and the ability to override someone's wishes only if a number of safeguards have been satisfied and the decision is deemed in that person's interests.

Conclusion

When we examine recent Scottish and UK mental health legislation, there is substantial evidence to support the majoritarian narrative. The UK process demonstrates the rejection by ministers of a negotiated settlement (by the Richardson Committee) and the attempt to impose measures based on public safety rather than patients' rights. This alienated most groups and the stand-off between groups and government was not resolved through bureaucratic accommodation. The experience of Scotland demonstrates not only a divergence in policy styles but also the effects of different styles on the substance of policy.

The Scottish legislation is comprehensive and includes elements of policy which were lost when the UK government withdrew its original bill.

Yet the UK process did not conform directly to the predictions of Lijphart (1999). In particular, there was never a period in which the government tried to impose policy *and* groups competed with each other. In 1983 group competition was merely refereed by the government; in the late 1990s groups demonstrated an impressive degree of cooperation with each other. There are also good reasons to believe that the Mental Health Act experience is atypical since it: extends to a small part of the mental health population, demonstrates an unusual combination of low ministerial interest but consistently high commitment and is not supported by the evidence in other areas. Examples such as the National Service Framework and the *Mental Capacity Act* show that the UK government style in mental health is relatively consensual, while a discussion of the 1959 and 1983 Acts suggests a long and proud history of modernisation through bureaucratic accommodation. Therefore, a key focus of this article is to explain why the UK government diverged so significantly from the 'normal' policy style in this case.

A comparison with the 1983 Act suggests that a number of key developments influenced temporarily the government's attitude to mental health. The unintended consequence of a reduction in hospital beds was a rise in media and public concern towards dangerous people with mental disorders living in the community. This was exacerbated by an inquiry system which kept the issue of mental health-related homicides high on the media agenda. ECHR developments also suggested that governments could be held responsible for not keeping the public safe. Together, these issues prompted an unusually high level of government interest in mental health, with the issue more likely to be framed as a matter of public safety and linked to New Labour's emphasis on crime and public order. At the same time, a period of group 'reinvention' produced a mental health policy network almost unanimously in favour of patients' rights. The shift in power to the Home Office and its agenda on DSPD alienated these groups and limited their traditional involvement through the Department of Health. The result was a lengthy period of conflict which became self-sustaining as pronouncements from each side exaggerated their differences. Most of these factors were absent in Scotland: there were more hospital beds, fewer high-profile homicides and a greater separation between mental health and crime which meant that there was no equivalent to the Home Office's influence and its agenda on DSPD. The issue of mental health also came at a good time, with the honeymoon period of devolution encouraging ministers to defer issues to expert reviews, and encouraging pressure participants to make the legislation work through cooperation and consensus.

These distinct policy conditions in England *at this time* may explain a temporary deviation from the 'normal' policy style described by the consensus narrative. This is not to say that there are no differences in policy styles between the Scottish and UK governments or that the latter's approach can be explained

entirely in terms of the strategic decision-making environment. Rather, this article provides further evidence that the UK government's majoritarian style is often exaggerated and that periods of top-down policy-making should be explained in detail rather than assumed to be the norm.

Notes

- 1 The term 'UK government' rather than 'UK' is used throughout, to make clear that although the UK government proposed the legislation, this only covers England and Wales. The 'British policy style' traditionally refers to the style of the UK government.
- 2 Only Scotland has the legislative capacity to make such comparisons (see Cairney, 2008 and Keating *et al.*, 2009 for a wider discussion of group-government relations since devolution). The Mental Health Act 2007 covers England and Wales, while mental health law is still to be updated in Northern Ireland. Although the Mental Health (Northern Ireland) Order 1986 was amended in 2004, more comprehensive measures have not yet followed the Bamford review (see <http://www.rmhdni.gov.uk/>).
- 3 Interviews in Scotland were supported by the ESRC (Keating, 2005). Interviews in Wales in 2005 and England in 2006 were supported by the University of Aberdeen. Ongoing research in England and Northern Ireland is supported by a Nuffield Small Grant (see Keating *et al.*, 2009).

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